Massachusetts STD, HIV/AIDS and Viral Hepatitis Surveillance Report: 2007

Massachusetts Department of Public Health
Bureau of Communicable Disease Control
Division of STD Prevention and HIV/AIDS Surveillance
Division of Epidemiology and Immunization

STD, HIV/AIDS and Viral Hepatitis Surveillance Summary – 2007
Massachusetts Department of Public Health

TABLE OF CONTENTS

INTRODUCTION

This report describes recent disease trends in sexually transmitted diseases (STDs), viral hepatitis and HIV/AIDS in Massachusetts. Detailed STD, viral hepatitis, and HIV/AIDS data by city and town can be accessed on the Internet at www.mass.gov/dph/cdc/std or http://www.mass.gov/dph/cdc/aids.

In addition to overall trends in STDs, viral hepatitis and HIV/AIDS, this summary provides a description of their impact on special populations: adolescents and young adults, women, and men who have sex with men (MSM). Certain racial/ethnic health disparities have also been highlighted.

This report is intended to be a user-friendly and easy-to-read reference for health care providers, local health departments and community-based organizations. Its goal is to provide an understanding of the public health importance of STDs, viral hepatitis, and HIV/AIDS in Massachusetts. MDPH contact information and website resources are available on pages 22 and 23. Additionally, page 20 includes a description of the strengths and limitations of the surveillance data, as well as notes on how to interpret STD, viral hepatitis, and HIV/AIDS data.

Unless otherwise noted, all incidence calculations represent crude rates. The source for all denominator data is the U.S. Census, 2000. All data reported are current as of September 1, 2008. All information on STD cases reflect year of report. Due to reporting delays related to the transition from code-base to name-based reporting of HIV cases, all HIV/AIDS data reflect HIV diagnosed through 2006.

ACKNOWLEDGEMENTS

This report was prepared by the following MDPH staff:

Thomas Bertrand, MPH	Daniel Church, MPH
Bill Dumas, RN	Franny Elson, MS
Gillian Haney, MPH	Katherine Hsu, MD, MPH
David Goudreau, LSW	Betsey John, MPH
Hillary Johnson, MPH	Jessica Malenfant, MPH
James Murphy, MPH	Sheila Nelson, MSW, MPH
Shauna Onofrey, MPH	Yuren Tang, MD, MPH

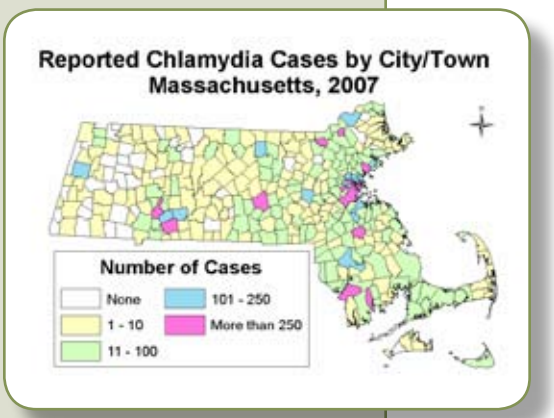
The MDPH acknowledges and appreciates the central role of health care providers and laboratories in disease reporting and the prevention/treatment of STDs, HIV/AIDS and viral hepatitis and the partnership with local public health in disease surveillance and control.

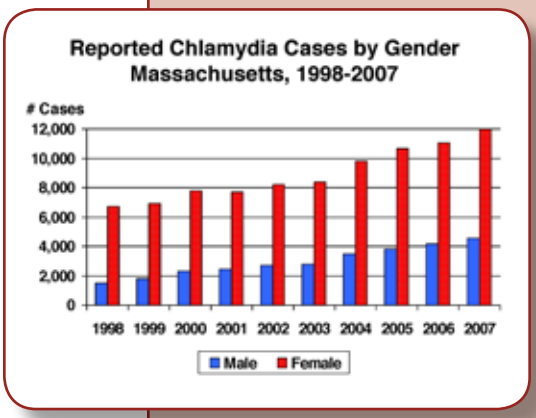
CHLAMYDIA

The overall number of reported chlamydia infections in Massachusetts in 2007 was 16,557. Chlamydia infection is widely distributed in Massachusetts.

Compared to 2006, there has been an increase in the number of cities and towns with case counts in the 11-100 range.

Chlamydia case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.

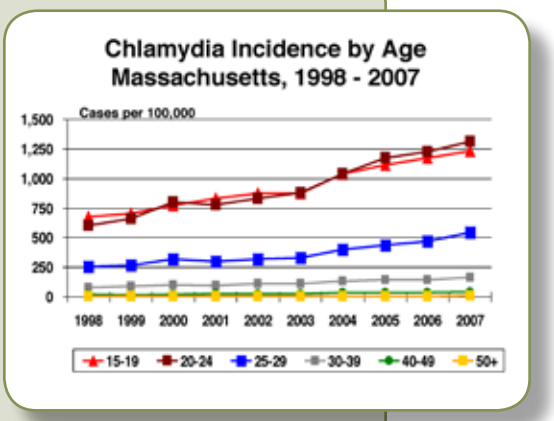




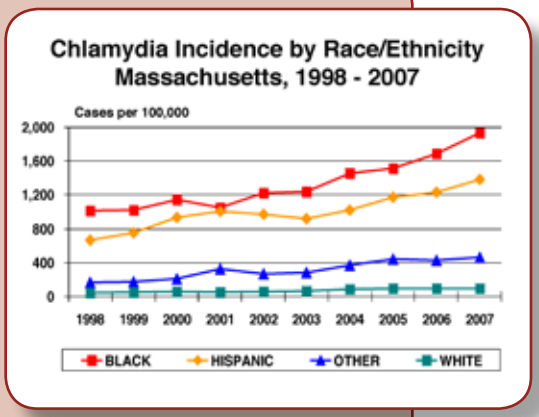
The total number of reported chlamydia infections in Massachusetts has more than doubled in the past ten years from 8,204 in 1998 to 16,557 in 2007. There was an 8.5% increase in the number of cases in 2007 compared to 2006.

Of the total reported cases in 2007, 4,577 were among men and 11,980 were among women. The greater number of chlamydia cases among women is partly attributable to a higher level of screening in women as compared to men.

In 2007, the incidence of reported chlamydia infection in Massachusetts among adolescents (ages 15-19) and young adults (ages 20-24) exceeded 1,000 per 100,000. This contrasts with the overall Massachusetts chlamydia infection rate of 260.6 per 100,000.



Historically, communities of color have been disproportionately affected by STDs. In 2007, compared to whites, the incidence of reported chlamydia infections in Massachusetts was 21 times higher among blacks and 15 times higher among Hispanics. The health disparity for chlamydia infection in Massachusetts has grown in recent years.



INFERTILITY PREVENTION PROJECT

Since 1997, the Division of STD Prevention has participated in a Centers for Disease Control and Prevention (CDC)-funded Infertility Prevention Project. The goal of this project is to reduce infertility and other health consequences of chlamydia infection through increased screening and treatment of women who are at higher risk for infection.

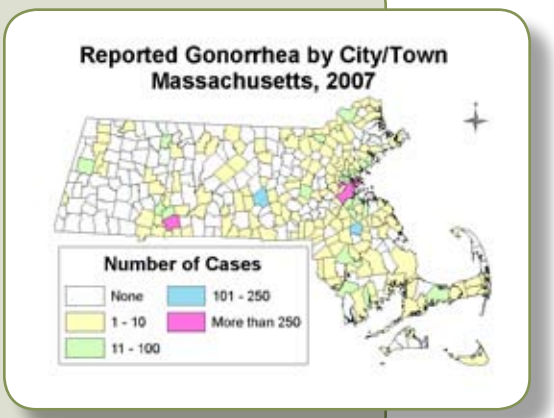
In 2007, as part of the Infertility Prevention Project, 19,754 specimens were tested for chlamydia infection. Test results from participating sites have yielded the following:

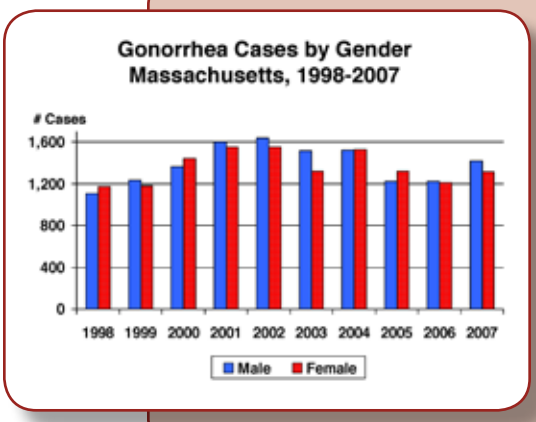
		PERCENT POSITIVE FOR CHLAMYDIA TRACHOMATIS	
SITE TYPE		FEMALES	MALES
School-Based Health Centers	(n = 719)	6.1%	5%
County Jails	(n = 3,996)	4%	6%
Family Planning Clinics	(n = 7,291)	4.6%	13.9%
STD Clinics	(n = 8,658)	7.4%	9.3%
Department of Youth Services	(n = 388)	3.1%	2.4%

GONORRHEA

The overall number of reported cases of gonorrhea in Massachusetts in 2007 was 2,733. Although gonorrhea is widely distributed in Massachusetts, numbers of cases are concentrated in urban locations.

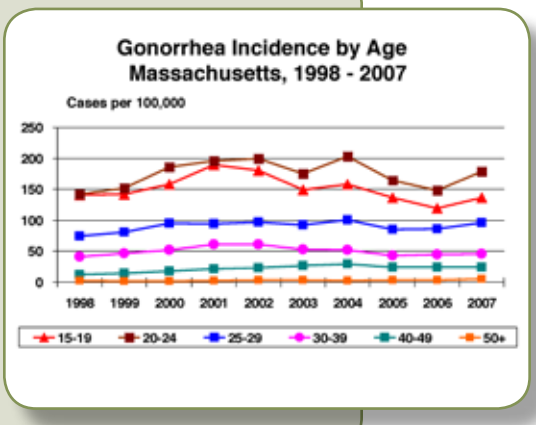
Gonorrhea case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.





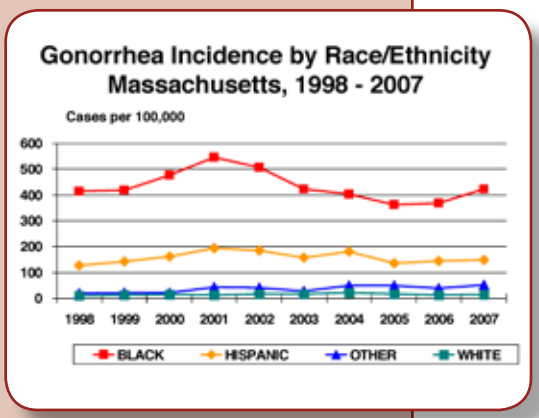
Massachusetts experienced an increase in reported gonorrhea cases from 1998–2002, followed by a decline from 2003–2006. There is a 10% increase in gonorrhea cases from 2006 to 2007. Of the 2,733 total cases in 2007, 1,315 were in women and 1,418 were in men.

The incidence of gonorrhea in Massachusetts is highest among young adults (ages 20-24), followed by adolescents (ages 15-19). Compared to the state-wide incidence (43.0 per 100,000) of gonorrhea, the incidence was 3.2 times higher for adolescents and 4.2 times higher for young adults.



In 2007, compared to whites, the reported gonorrhea incidence in Massachusetts was 26.4 times higher among blacks and 9.4 times higher among Hispanics.

The health disparity gap in gonorrhea rates in Massachusetts exceeds the national rate, where the incidence in gonorrhea is 18 times higher among blacks, and 2 times higher among Hispanics, when compared to whites. (Source: CDC. Sexually Transmitted Disease Surveillance, 2005. Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)



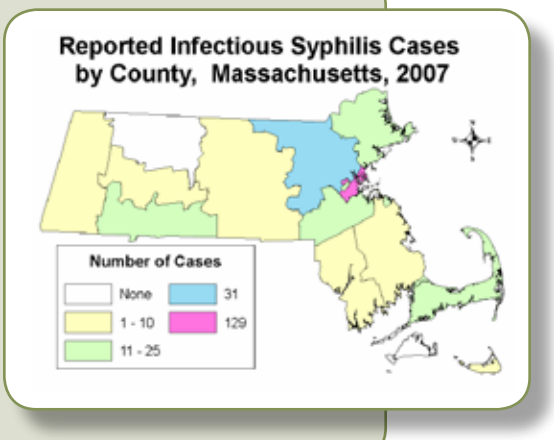
TRENDS IN ANTIBIOTIC RESISTANT GONORRHEA

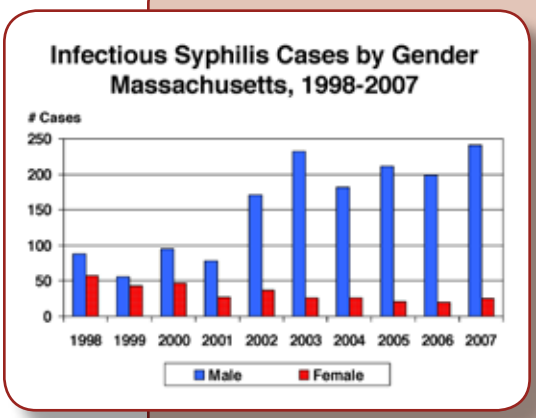
Quinolone-resistant *Neisseria gonorrhoeae* (QRNG) is a strain of the bacteria and may not be cured by standard oral antibiotic therapies. QRNG often requires more aggressive approaches to diagnosis and treatment.

Results from the QRNG Prevalence Monitoring Project at the MDPH William A. Hinton State Laboratory Institute indicate that the prevalence of QRNG continues to rise in Massachusetts. The proportion of QRNG among positive gonorrhea cultures increased from 13.5% in 2003 to 24.6% in 2007. Ninety-six percent of QRNG cases were identified among men, and 78% of the men who tested positive for QRNG self-identified as men who have sex with men (MSM).

In 2007, there were 266 reported infectious primary, secondary, and early latent syphilis cases in Massachusetts, a 22% increase since 2006. Although infectious syphilis cases have been reported in almost all counties, 48% of cases (129) were reported from Suffolk County.

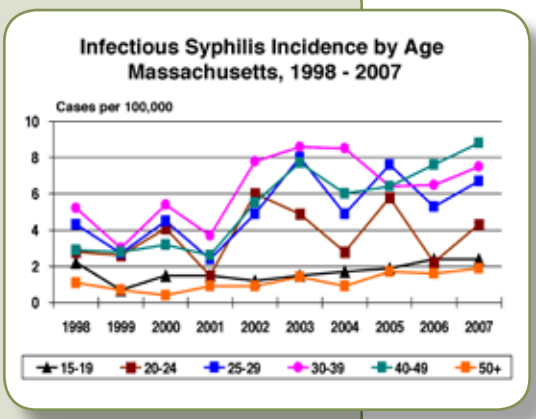
Infectious syphilis case and incidence data by city and town are available online at www.mass.gov/dph/cdc/std.



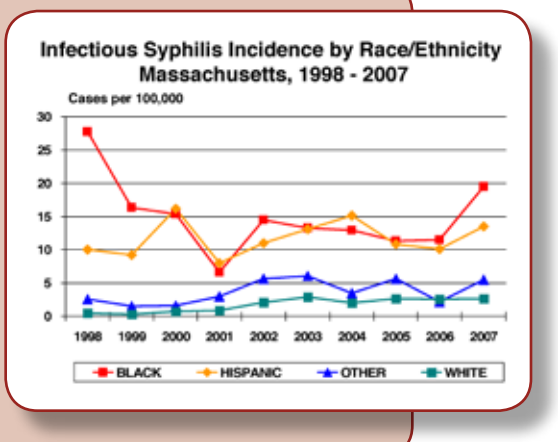


In Massachusetts, the male-to-female ratio of infectious syphilis cases changed from 1.5 to 1 in 1998, to 9.6 to 1 in 2007. This shift reflects an increase in the number of infectious syphilis cases diagnosed in men who have sex with men. This trend has also been observed in other regions of the United States.

In contrast to chlamydia infection and gonorrhea, which tend to occur more frequently among adolescents and young adults, infectious syphilis is more commonly reported in people over age twenty-five years.



In 2007, compared to whites, the reported infectious syphilis incidence in Massachusetts was 7 times higher among blacks and 5 times higher among Hispanics.



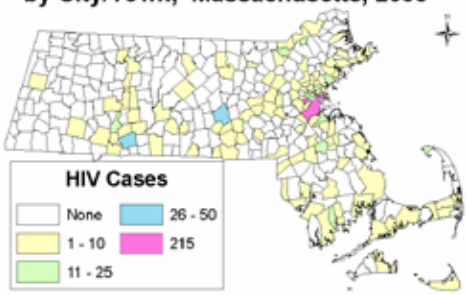
SYPHILIS IN MEN WHO HAVE SEX WITH MEN (MSM)

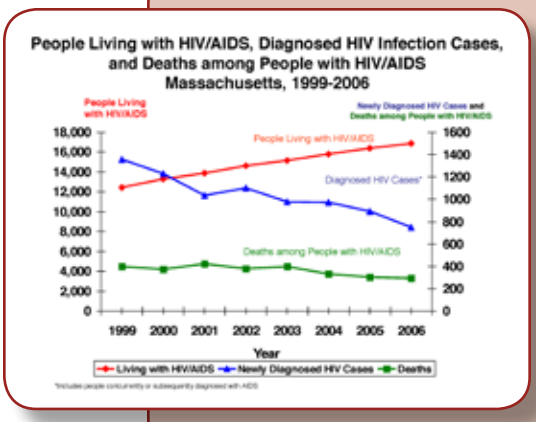
In Massachusetts, MSM represent a higher-risk group for infectious syphilis. Of the 266 reported infectious syphilis cases in 2007, 183 (69%) were in MSM. Forty-eight percent (88/183) of the MSM with infectious syphilis disclosed that they were co-infected with HIV. Forty-six percent (84/183) of the infectious syphilis cases in MSM were reported in Suffolk county.

Transmission of syphilis can occur between men through unprotected oral and anal sex. Additional information and resources regarding MSM and STDs is available online at **www.gettestedboston.org.**

Of the 351 cities and towns in Massachusetts, 128 (36.5%) had at least one reported, newly diagnosed HIV infection in 2006. The majority of newly identified HIV infections were reported in large urban areas.

2006 HIV case and incidence data by city and town are available online at www.mass.gov/dph/cdc/aids. Additional information is available through the MDPH HIV/AIDS Epidemiologic Profile at the same weblink.

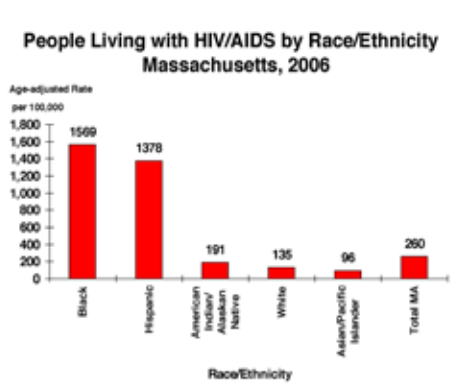




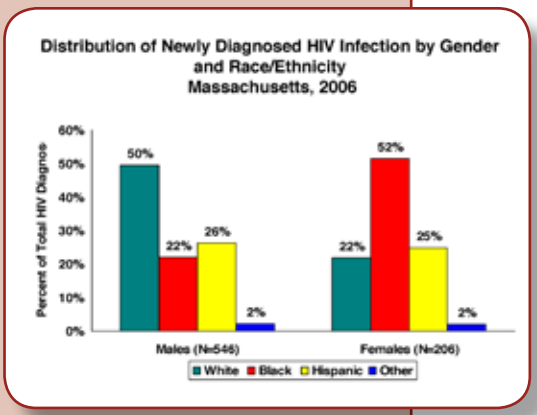
In 2006, there were 752 reported, newly diagnosed HIV infections and 294 deaths among people with HIV/AIDS in Massachusetts.

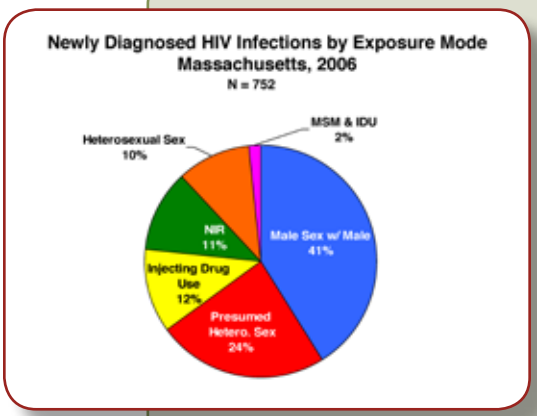
The number of people known to be living with HIV/AIDS in Massachusetts has increased from 12,420 in 1999 to 16,878 in 2006.

In Massachusetts, in 2006, the prevalence rate of people living with HIV/AIDS was highest among blacks and Hispanics. As compared to whites, the rate of people living with HIV/AIDS was 11.7 times higher among blacks and 10.2 times higher among Hispanics.



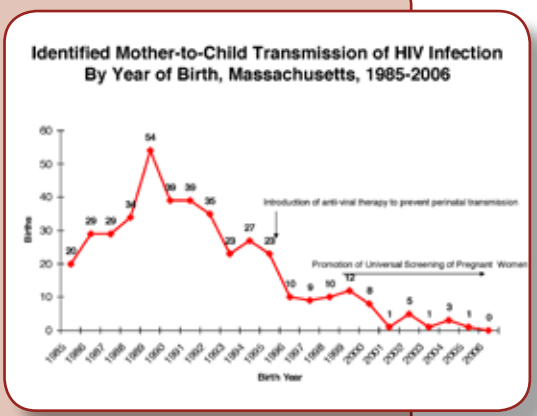
In 2006, of the 752 newly diagnosed HIV infections in Massachusetts, 546 (73%) were in men and 206 (27%) were in women. Most of newly diagnosed HIV infections in men were in white men, and the majority of newly diagnosed HIV infections in women were in black women.





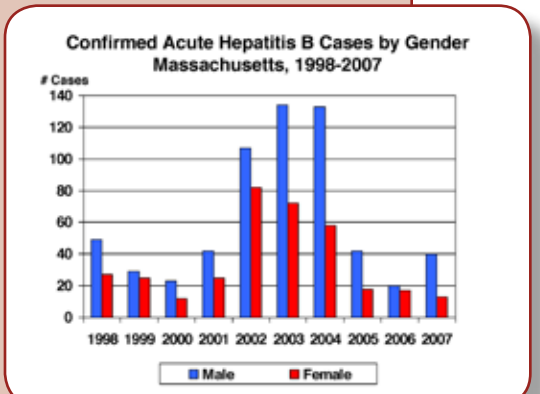
In 2006, the primary exposure modes reported among newly diagnosed HIV cases in Massachusetts were male with male sex (41%), presumed heterosexual sex (24%), and heterosexual sex (10%).

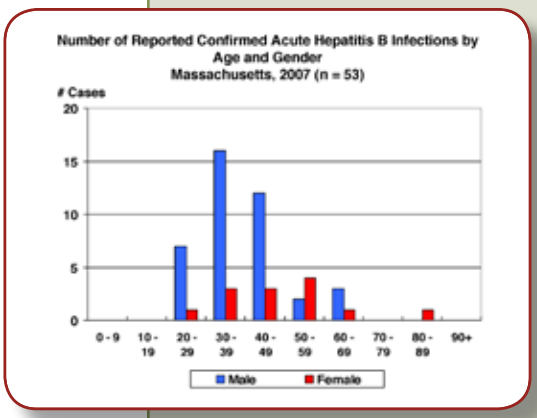
Since the mid-1990's, Massachusetts has experienced a dramatic reduction in mother-to-child transmission of HIV infection, with no HIV-infected newborns identified in 2006. This success is attributed to improvements in HIV screening during pregnancy and the treatment of HIV-infected women with anti-retroviral therapy.



VIRAL HEPATITIS

In 2007, 53 cases of confirmed acute hepatitis B infection were reported in Massachusetts. This is comparable to the number of acute hepatitis B cases reported in 2005, although higher than the number reported in 2006. A peak of recently reported cases was observed in 2003, with 204 cases. The increase and subsequent decline in cases may have been the result of enhanced surveillance followed by a more restrictive case definition established by CDC.



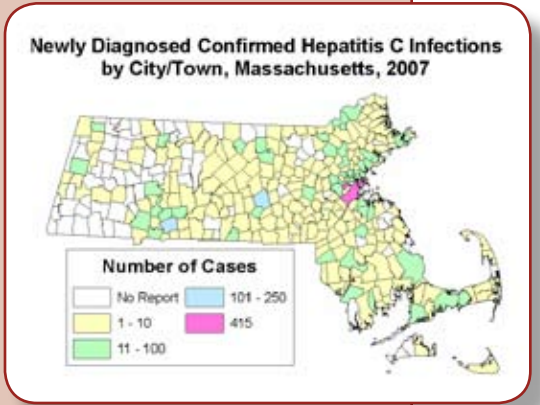


In 2007, the highest incidence of acute hepatitis B among males was in the 30-39 year-old age group, and in females, in the 50-59 year-old age group.

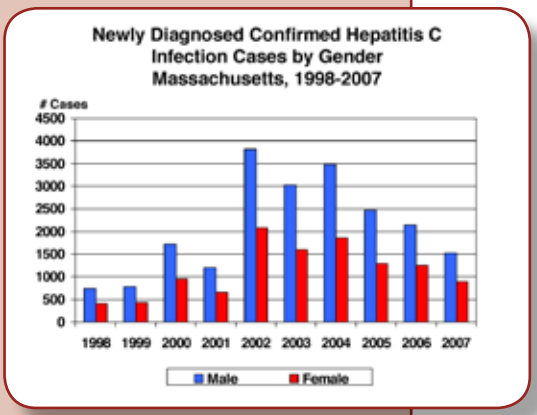
Of the total acute cases reported, 79% occurred in persons between the ages of 20 and 49 years.

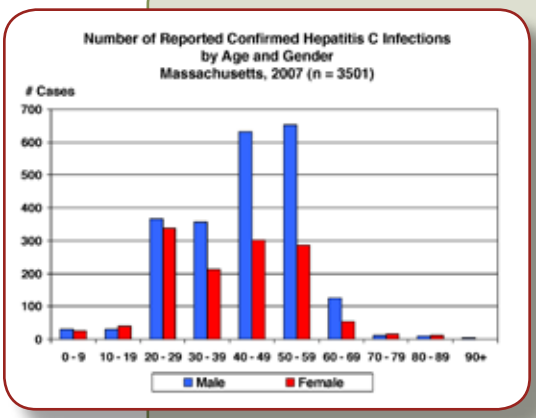
The absence of hepatitis B cases in people under age 20 is largely attributable to infant hepatitis B immunization, as well as school-entry vaccination requirements.

Overall there were 2,435 confirmed cases of hepatitis C infection reported in Massachusetts in 2007. The highest concentrations of cases were in the urban areas of Boston, Worcester, and Springfield.



There was a 28% decline in the number of reported, diagnosed, confirmed hepatitis C infection cases reported from 2006 to 2007. This is the lowest number of cases reported since 2001.





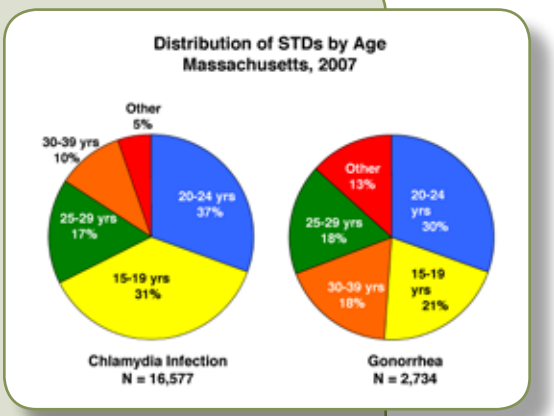
In 2007, the highest incidence of reported hepatitis C among males was in the 50-59 year-old age group. In females, the 20-29 year-old age group had the highest reported rates. This may be due, in part, to increased testing in this age group.

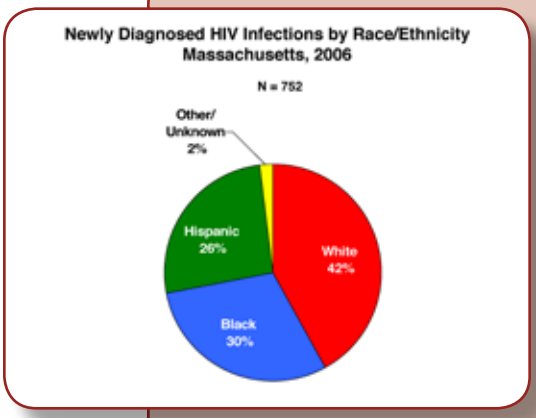
Of all newly diagnosed hepatitis C cases reported, 52% occurred in persons between the ages of 40 and 59 years.

STDs IN ADOLESCENTS AND YOUNG ADULTS

Compared to older adults, sexually active adolescents and young adults are at higher risk for acquiring STDs. This higher risk is due to a combination of behavioral, biological and cultural factors. The higher prevalence of STDs among adolescents also reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. (Source: CDC. Sexually Transmitted Disease Surveillance, 2005. Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)

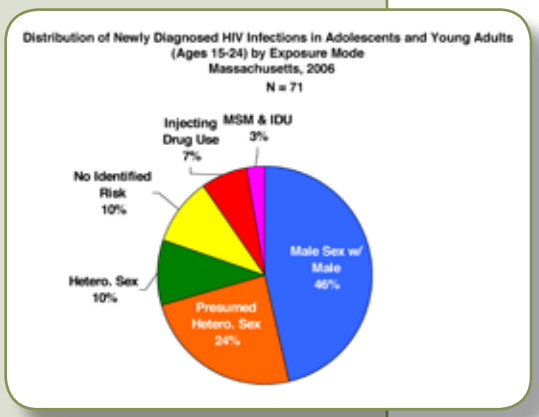
In 2007, 67% of reported chlamydia infection cases, and 51% of reported gonorrhea cases, were in adolescents and young adults (ages 15-24).





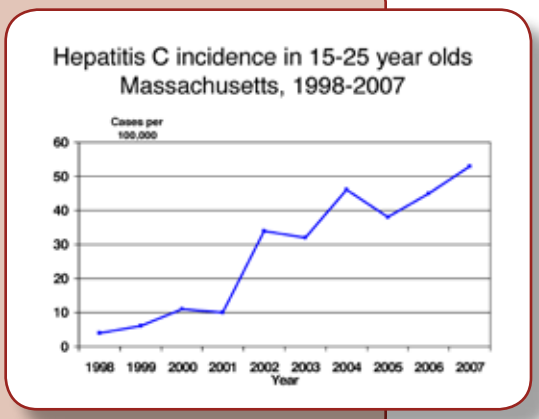
In 2006, reported, newly diagnosed HIV infections among adolescents and young adults in Massachusetts had the following racial ethnic distribution: black (32%), white (34%), Hispanic (31%), and other (3%).

In 2006, in Massachusetts, the primary modes of exposure for reported, newly diagnosed HIV infection cases in adolescents and young adults were male with male sex (46%), presumed heterosexual (24%), heterosexual (10%), and injecting drug use (7%).



There has been a trend of increased HCV infection in youth ages 15 to 25 years. From 2002 to 2007, the incidence of confirmed hepatitis C cases in 15-25 yearolds increased from 34 to 53 per 100,000.

Factors that may be contributing to this increase include enhanced surveillance, as well as increased injection drug use (heroin) among adolescents and young adults.



SEXUAL BEHAVIORS AMONG MASSACHUSETTS HIGH SCHOOL STUDENTS BY GENDER, 2007

	AFFIRMATIVE RESPONSES	
	MALES	FEMALES
Respondents: All students		
Lifetime sexual intercourse	45.2%	43.7%
Sexual intercourse before age 13	8.6%	3.6%
Four or more lifetime sexual partners	14.1%	10.6%
Respondents: Students having sexual intercourse in past three months		
Condom use at last sexual intercourse	63.2%	59.2%
Substance use at last sexual intercourse	27.7%	21.9%
Respondents: Students ever having sexual intercourse		
Ever been or gotten someone pregnant	8.5%	10.9%
Ever been diagnosed with HIV or STD	3.3%	3.3%

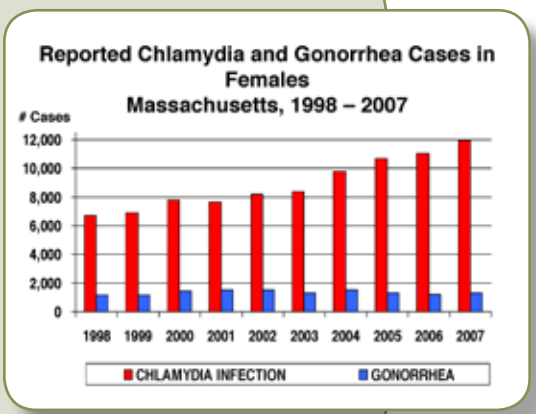
Source: Youth Risk Behavior Survey: www.doe.mass.edu/cnp/hprograms/yrbs/

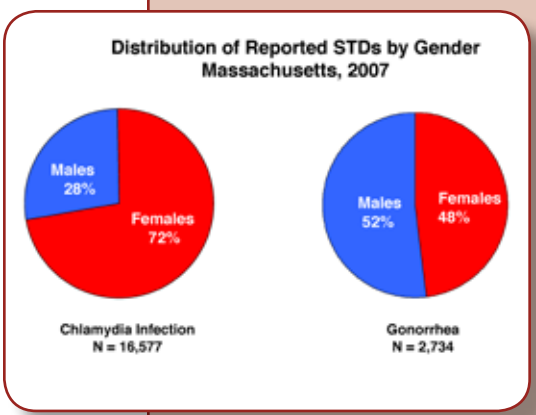
STDs AND WOMEN

Complications of STDs are greater and more frequent among women than men due to two primary factors. First, biologically, women are more likely than men to become infected if exposed to an STD. Second, STDs are more likely to remain undetected in women, resulting in delayed diagnosis and treatment, and ultimately more untreated infections leading to complications. (Source: The Hidden Epidemic, Institute of Medicine, National Academy Press, Washington, D.C., 1997.)

Untreated STDs in women can lead to serious health consequences, including pelvic inflammatorydisease, infertility, ectopic pregnancy and cervical cancer.

Unlike gonorrhea, reported chlamydia infection in Massachusetts is more common in women and has been increasing in the past ten years, in part due to increased adoption of routine screening by healthcare providers.

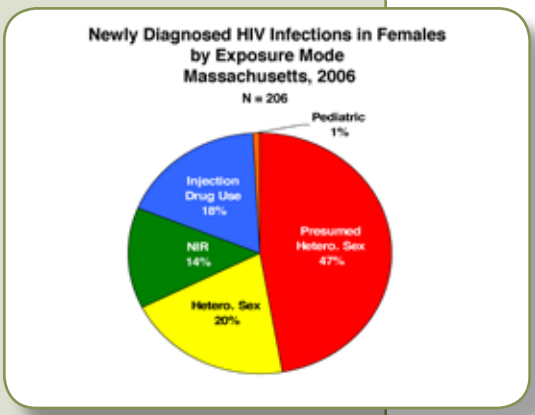




While gonorrhea cases are almost equally distributed between women and men, women are over-represented among chlamydia cases by a ratio of 2.6 to 1.

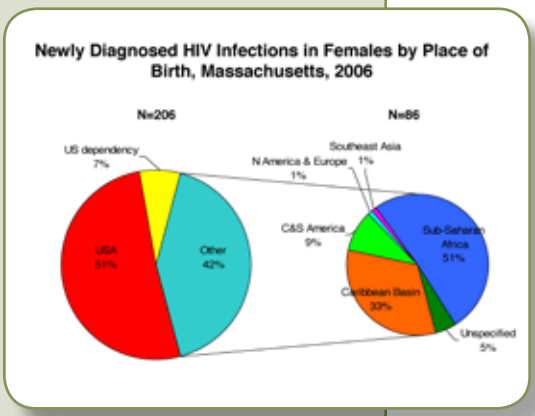
The greater number of chlamydia cases in women is attributable to increased screening in women as compared to men.

In 2006, the exposure mode for the 206 newly diagnosed HIV cases reported in women in Massachusetts was attributed to presumed heterosexual sex (47%), heterosexual sex (20%), no identified risk (14%), injecting drug use (18%), and pediatric exposure (1%).



In 2006, 42% of women reported with newly diagnosed HIV infection were born outside of the U.S. For men diagnosed in 2006, 24% were born outside of the U.S.

Eighty-three percent of women diagnosed with HIV infection, who were born outside of the U.S., were born in regions of the world where heterosexual sex is the predominant mode of transmission of HIV infection.



HIGH-RISK HUMAN PAPILLOMAVIRUS PREVALENCE

In a study of 2,048 Massachusetts women aged 18-65 years attending STD, family planning, and primary care clinics for routine cervical screening, overall age- and clinic-type adjusted prevalence of high-risk human papillomavirus (HPV)* was 19%. Prevalence was highest among women 14 –19 years of age. (Source: Datta et al., HPV infection and cervical cytology in women screened for cervical cancer in the U.S., 2003-2005. Annals of Internal Medicine, 148:493-500, 2008.)

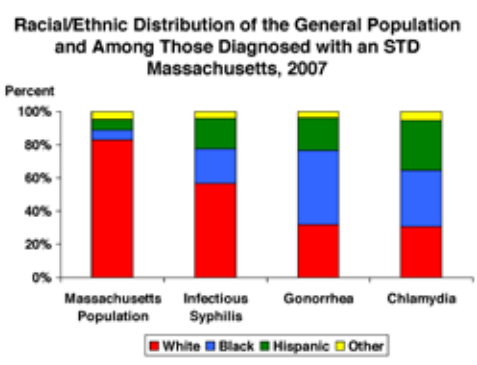
*High-risk HPV types were 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68.

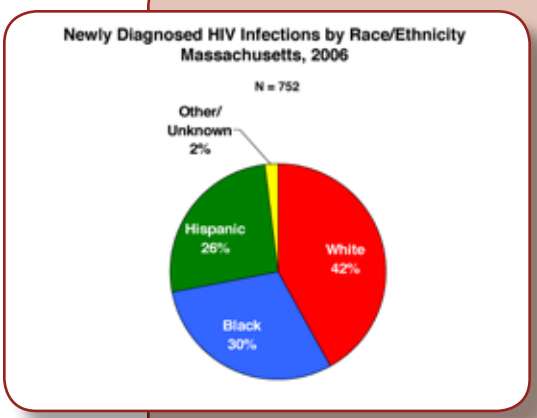
RACIAL/ETHNIC DISPARITIES IN STD RATES

Reasons for the racial and ethnic differences in STD rates are unclear and complex. Possible explanations for these differences include socioeconomic status, variability in access to and utilization of health care, differences in sexual behavior, and varying risk of STDs among sexual networks. (Source: The Hidden Epidemic, Institute of Medicine, National Academy Press, Washington, D.C., 1997)

Although communities of color represent only 18% of the total Massachusetts population, these communities bear a disproportionate burden of STDs. In 2007, 44% of the reported infectious syphilis cases,

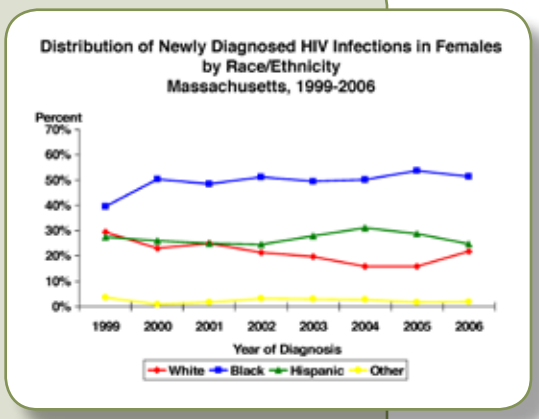
68% of the reported gonorrhea cases, and 69% of the reported chlamydia infection cases occurred in individuals from communities of color.



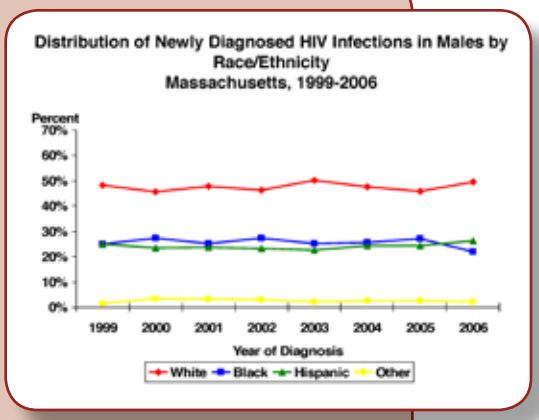


In 2006, the racial/ethnic distribution of reported, newly diagnosed HIV infections in Massachusetts was as follows: white (42%), black (30%), Hispanic (26%), and other/unknown (2%).

In Massachusetts, black and Hispanic women bear a higher burden of HIV infection compared to women of other races/ethnicities.



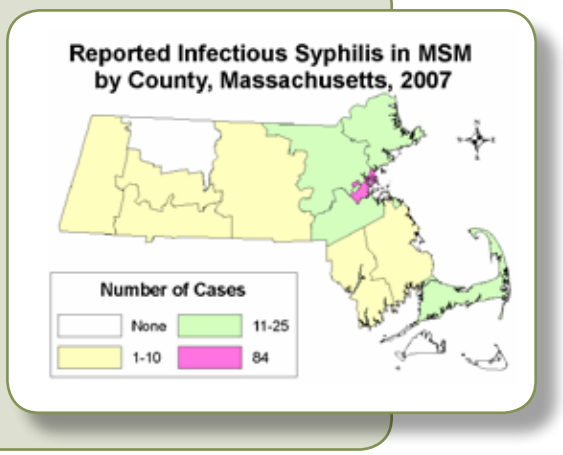
In Massachusetts, the absolute number of reported cases of HIV infection among men is greatest in white men. However overall, blacks and Hispanics have the highest rates of HIV infection per capita (See page 8 for the rates of persons living with HIV/AIDS by race/ethnicity.)

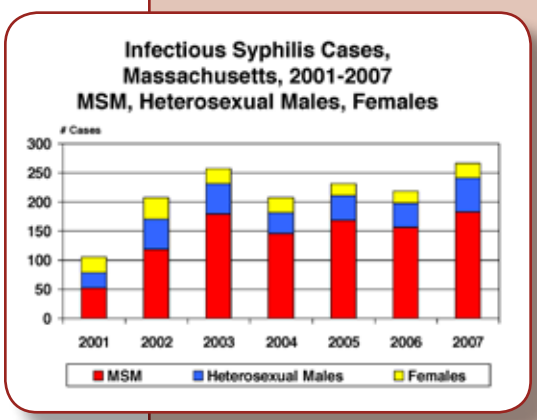


STDs IN MEN WHO HAVE SEX WITH MEN

Data from several U.S. cities suggest that an increasing number of men who have sex with men (MSM) are acquiring STDs. Data also suggest that an increasing number of MSM are engaging in sexual behaviors that place them at risk for STDs and HIV infection. Because STDs and the behaviors associated with them increase the likelihood of acquiring and transmitting HIV infection, the rise in STDs among MSM may be associated with an increase in HIV incidence among MSM. (Source: CDC. Sexually Transmitted Disease Surveillance, 2005. Atlanta, GA: U.S. Department of Health and Human Services, November 2006.)

In 2007, there were 183 infectious syphilis cases in men who have sex with men (MSM) reported in Massachusetts, of which, 84 (46%) were in Suffolk County.

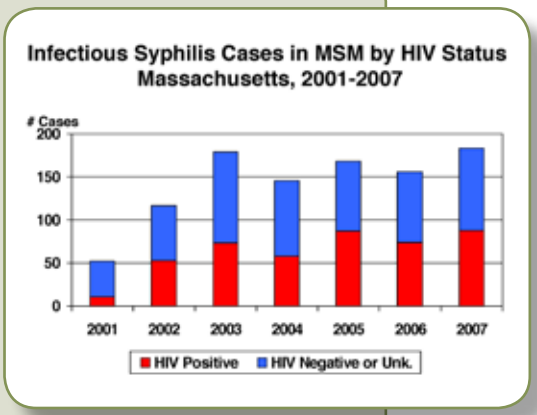




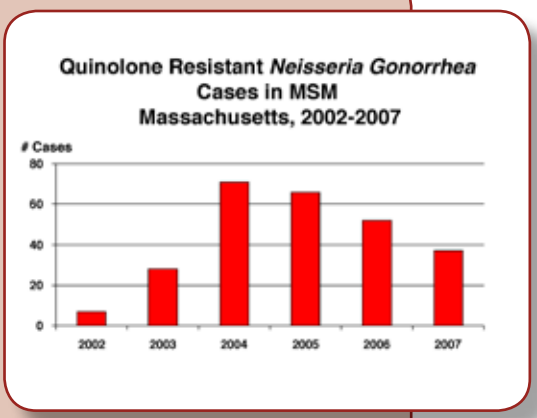
In the past six years, men who have sex with men accounted for the majority of infectious syphilis cases in Massachusetts, ranging from 50% in 2001 to 69% in 2007.

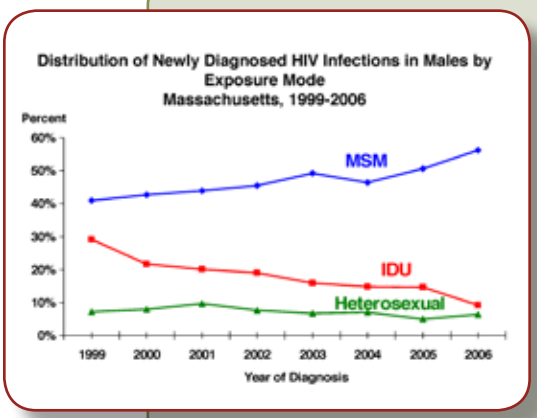
In 2007, the racial/ethnic breakdown of reported infectious syphilis cases in MSM was white (64%), black (15%), Hispanic (13%), other (3%), and unknown (4%). The median age of the cases was 41 years.

In 2007, 48% of the reported infectious syphilis cases in MSM occurred in HIV-positive individuals.



Results from the Quinolone Resistant Neisseria Gonorrhea (QRNG) Prevalence Project indicate a rise in quinolone-resistant gonorrhea in MSM in Massachusetts. The Project reported 7 QRNG cases in 2002 and 37 QRNG cases in 2007.





Among males, the proportion of reported male HIV infection cases with male to male sex as the reported mode of exposure increased from 41% in 1999 to 56% in 2006.

Summary of Strengths and Limitations of Data

	HIV/AIDS Case Data	STD Case Data	Viral Hepatitis Case Data
Description	• Collected by MDPH Bureau of Communicable Disease Control, HIV/AIDS Surveillance Program. • Reportable statewide. • All licensed healthcare providers are required by law to report. • AIDS HIV infection cases are reported by name, but HIV cases included in this report were reported by a code extracted from identifiers from 1999 through 2006.	• Collected by MDPH Bureau of Communicable Disease Control, Division of STD Prevention. • Reportable statewide. • All healthcare providers are required by law to report nine STDs, including syphilis, gonorrhea, chlamydia infection, and lymphoma granuloma venereum	• Collected by MDPH Bureau of Communicable Disease Control, Office of Integrated Surveillance and Informatics Services. • Reportable statewide. • All laboratories and healthcare providers are required to report laboratory indicators of hepatitis B and C infection.
Strengths	• Statewide reporting, population-based. • Risk information is available. • Completeness of reporting is high. • Comparable with other states.	• Statewide reporting, population-based. • Comparable with other states. • Enhanced reporting of positive laboratory results.	• Statewide reporting, population-based. • Enhanced reporting of acute cases, hepatitis B cases in child-bearing aged women and children and hepatitis C cases among youth ages 15-25.
Limitations	• Under-reporting (10%-15%) hampers interpretation of AIDS case data. • Not all AIDS cases are reported at time of diagnosis (reporting lag). • HIV data may be incomplete because some HIV-infected people may not have been tested or have entered care.	• Under-reporting of up to 10% of STD cases. • Race/ethnicity is missing in 31% of gonorrhea cases and 37% of Chlamydia infection cases. • Reports are not received on those not seeking care or screening. • Bias is introduced for some STDs, such as Chlamydia infection, where screening of asymptomatic persons occurs more frequently in women than in men.	• Race data are missing in 56% of confirmed acute hepatitis B and 80% of confirmed hepatitis C cases; ethnicity data are missing in 58% of acute hepatitis B and 75% of confirmed hepatitis C cases. • Risk history data is missing in a majority of reported hepatitis B and C cases. • Reports not received on those not seeking care.

I. HIV/AIDS Exposure Mode Definitions

The HIV/AIDS exposure mode indicates the most probable risk behavior associated with HIV infection. Assignment of exposure mode is done in accordance with Centers for Disease Control and Prevention guidelines when multiple exposure modes are reported. Following is a description of the exposure mode categories:

- **MSM (Male to Male Sex)**: Includes men who report sexual contact with other men, and men who report sexual contact with both men and women.
- **IDU (Injection Drug Use)**: Cases in persons who report injection drug use.
- **MSM/IDU**: Cases in men who report both injection drug use and sexual contact with other men.
- **Heterosexual Sex**: Cases in persons who report specific heterosexual sex with a person with, or at increased risk for, HIV infection (e.g. an injection drug user). The sub-categories for this mode of transmission are listed below.
    - *Heterosexual Sex w/ an Injection Drug User*
    - *Heterosexual Sex w/ a person w/ HIV infection or AIDS*
    - *Heterosexual Sex w/Bisexual male*
    - *Other Heterosexual Sex*: Includes all other sub-categories of risk, such as heterosexual contact with a person infected through a blood transfusion.
- **Presumed Heterosexual**: Cases in persons who report heterosexual sex but do not report any other personal risk nor any knowledge of specific risk in their sex partners. Presumed Heterosexual is an exposure mode category used by the Massachusetts HIV/AIDS Surveillance Program. The Centers for Disease Control and Prevention (CDC) categorizes these cases as No Identified Risk.
- **Pediatric**: Infection before the age of 13 years, including mother to child transmission through pregnancy, childbirth or breastfeeding and blood transfusions to children.
- **NIR (No Identified Risk)**: Cases in persons with no reported history of exposure to HIV through any of the listed exposure categories. Follow-up is conducted to determine risk for those cases that are initially reported without a risk identified.

II. Race/Ethnicity of STD and HIV/AIDS Cases

Race/ethnicity references to whites and blacks represent persons who are white non-Hispanic and black non-Hispanic, respectively. All references to Hispanic for race/ethnicity represent persons of Hispanic heritage regardless of race.

III. References to Newly Diagnosed HIV Infections

Newly diagnosed HIV infections/cases include all persons diagnosed with HIV in 2006, including those who were concurrently or subsequently diagnosed with AIDS.

STD, HIV/AIDS and Viral Hepatitis Resources

DIVISION OF STD PREVENTION AND HIV SURVEILLANCE			
Topic	**Contact**	**E-Mail**	**Phone**
Policy Development and Administration	Thomas Bertrand **(Division Director)**	thomas.bertrand@state.ma.us	617-983-6941
Sylvie Ratelle STD/HIV Prevention Training Center	Katherine Hsu **(Medical Director)**	katherine.hsu@state.ma.us	617-983-6948
	Janine Dyer **(Coordinator)**	janine.dyer@state.ma.us	617-983-6964
HIV/AIDS Surveillance and Epidemiology	Jim Murphy **(Director)**	james.murphy2@dph.state.ma.us	617-983-6577
	Yuren Tang **(Epidimiologist)**	yuren.tang@state.ma.us	617-983-6554
STD Clinical Services	Bill Dumas **(Clinical)**	bill.dumas@state.ma.us	617-983-6950
STD Disease Intervention Field Services and STD Partner Notification	Hillary Johnson **(Director of Field Services)**	hillary.johnson@state.ma.us	617-983-6951
STD Health Education, Training, and Prevention	Sheila Nelson	sheila.nelson@state.ma.us	617-983-6961
	David Goudreau	david.goudreau@state.ma.us	617-983-6835
HIV/AIDS BUREAU			
Policy, Planning, Resource Allocation, Research, and Evaluation	Kevin Cranston **(Bureau Director)**	kevin.cranston@state.ma.us	617-624-5303
	Deborah Isenberg **(Director of Research and Evaluation)**	deborah.isenberg@state.ma.us	617-624-5311
	Thera Meehan **(Director of Policy and Planning)**	thera.meehan@state.ma.us	617-624-5328
	Tammy Goodhue **(Director of Training and Health Communication)**	tammy.goodhue@state.ma.us	617-624-5338
Administration and Finance, Personnel, Contracts and Procurement, Budget	Bob Carr **(Deputy Bureau Director)**	bob.carr@state.ma.us	617-624-5317
	Ceci Dunn **(Director of Operations)**	ceci.dunn@state.ma.us	617-624-5370
Consumer Office	Sophie Lewis **(Director of Consumer Office)**	sophie.lewis@state.ma.us	617-624-5366
	Paul Goulet **(Consumer Office Coordinator)**	paul.b.goulet@state.ma.us	617-624-5389
Prevention and Education	Barry Callis **(Director of AIDS Prevention and Education)**	barry.callis@state.ma.us	617-624-5316
HIV Clinical Care, Home-Based HIV Care, HIV Counseling and Testing, Corrections-Based HIV Services	Brenda Cole **(Director of Health Services)**	brenda.l.cole@state.ma.us	617-624-5333
HIV Client Services, Case Management, Peer Support Services, Housing Support Services, Service Coordination Collaboratives	Linda Goldman **(Director of Client Services)**	linda.goldman@state.ma.us	617-624-5347

STD, HIV/AIDS and Viral Hepatitis Contact Information

Training

Professional training to community based organizations, local public health departments, and medical providers can be requested and is free of charge.

Type of Training	Contact Information and Website
STD Education, STD Partner Notification, and STD Reporting	617-983-6940 www.mass.gov/dph/cdc/std
HIV/AIDS Reporting and Surveillance Projects	617-983-6560 www.mass.gov/dph/cdc/aids
HIV/AIDS Provider Trainings	508-752-7313 www.mass.gov/Eeohhs2/docs/dph/aids/prov_training_calendar.pdf
Viral Hepatitis Education	617-983-6800 http://www.mass.gov/dph/cdc/epii/imm/imm.htm
STD/HIV Diagnosis, Treatment, and Management	617-983-9645 www.mass.gov/dph/cdc/stdtcmai/courses.htm

Material and Clinical Toolkits

Health education materials and clinical toolkits can be requested free of charge.

STD, HIV, Viral Hepatitis Fact Sheets	617-983-6940 or 617-624-5338 www.mass.gov/dph/cdc/factsheets/factsheets.htm
HIV/AIDS Reporting for Health Care Providers Brochure	617-983-6560 www.mass.gov/dph/cdc/aids/hiv_report_for_health_care_providers.htm
Viral Hepatitis Posters and Brochures	617-983-6800 www.mass.gov/dph/cdc/epii/hepatitis/hepa.htm or www.mass.gov/hepc
STD/HIV Diagnosis, Treatment, and Management Toolkits	617-983-9645 www.mass.gov/dph/cdc/stdtcmai/stdtcmai.htm

MDPH and MDPH Funded Websites

Division of STD Prevention	www.mass.gov/dph/cdc/std
HIV/AIDS Bureau	www.mass.gov/dph/aids
HIV/AIDS Surveillance	www.mass.gov/dph/cdc/aids
Viral Hepatitis Program	
Hepatitis C	www.mass.gov/hepc
Hepatitis A	www.mass.gov/dph/cdc/epii/hepatitis/hepa.htm
Sylvie Ratelle STD/HIV Prevention Training Center	www.mass.gov/dph/cdc/stdtcmai/stdtcmai.htm
GetTestedBoston (for MSM)	www.gettestedboston.org
URhealthstyle (for Urban Teens)	www.URhealthstyle.com

National Websites

Center for Disease Control and Prevention	www.cdc.gov
Division of STD Prevention	www.cdc.gov/std
Division of HIV/AIDS Prevention	www.cdc.gov/hiv
Division of Viral Hepatitis	www.cdc.gov/ncidod/diseases/hepatitis
National Network of STD/HIV Prevention Training Centers	www.stdhivpreventiontraining.org